Reprinted
April 1, 2005

ENGROSSED
SENATE BILL No. 66

DIGEST OF SB 66 (Updated March 31, 2005 5:53 pm - DI 77)

Citations Affected: IC 12-15; IC 12-16; IC 29-2; IC 34-30.

Synopsis: Hospital care and reimbursement under Medicaid and organ procurement. Extends provisions of law that: (1) prohibit the office of Medicaid policy (office) or the office's managed care contractor from providing incentives or mandates that direct certain individuals to specified hospitals other than the hospital located in the city where the patient resides unless specified conditions are met; (2) require reimbursement for specified hospitals for services provided if certain conditions are met; and (3) require an inflation adjustment factor to be applied to the reimbursements. Requires an emergency department physician to notify a managed care organization after providing treatment to a recipient. Extends the deadline in which a hospital has to file an application for the hospital care for the indigent program (program) from 30 days to 45 days. Specifies the services or items

(Continued next page)

Effective: July 1, 2003 (retroactive); December 30, 2004 (retroactive); December 31, 2004 (retroactive); upon passage; July 1, 2005.

Dillon, Rogers, Smith S
(HOUSE SPONSORS — BECKER, BROWN C)

January 4, 2005, read first time and referred to Committee on Rules and Legislative Procedure.
February 15, 2005, amended; reassigned to Committee on Health and Provider Services.
February 24, 2005, reported favorably — Do Pass.
February 28, 2005, read second time, amended, ordered engrossed.
March 1, 2005, engrossed. Read third time, passed. Yeas 49, nays 0.

HOUSE ACTION
March 10, 2005, read first time and referred to Committee on Public Health.
March 24, 2005, amended, reported — Do Pass.
March 31, 2005, read second time, amended, ordered engrossed.

included as a payable claim in the program. Makes changes to the procedures and requirements to file a claim and determine eligibility in the program. Provides immunity for administration of certain agreements between a hospital and the division of family and children. Requires a managed care organization to reimburse certain emergency department screening exams. Requires a coroner to attempt to facilitate permission for transplantation of organs, tissues, and eyes. Establishes procedures that a pathologist must follow if the pathologist considers withholding organs or tissues. Requires the procurement organization to provide reimbursement for the cost of organ removal if the pathologist is required to be present to examine the decedant. Provides that if a procurement organization has an agreement to perform anatomical gift services at a hospital the procurement organization is considered the donee for gifts from patients who die at the hospital.

Reprinted
April 1, 2005

First Regular Session 114th General Assembly (2005)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~
Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.
Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

ENGROSSED
SENATE BILL No. 66

A BILL FOR AN ACT to amend the Indiana Code concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-11.5-3.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE DECEMBER 30, 2004 (RETROACTIVE)]: **Sec. 3.1. (a) The office or the office's managed care contractor may not provide incentives or mandates to the primary medical provider to direct individuals described in section 2 of this chapter to contracted hospitals other than a hospital in a city where the patient resides.**

(b) The prohibition in subsection (a) includes methodologies that operate to lessen a primary medical provider's payment due to the provider's referral of an individual described in section 2 of this chapter to the hospital in the city where the individual resides.

(c) If a hospital's reimbursement for nonemergency services that are provided to an individual described in section 2 of this chapter is established by:

(1) statute; or

(2) an agreement between the hospital and the individual's managed care contractor;

the hospital may not decline to provide nonemergency services to the individual on the basis that the individual is enrolled in the Medicaid risk based program.

(d) A hospital that provides services to individuals described in section 2 of this chapter shall comply with eligibility verification and medical management programs negotiated under the hospital's most recent contract or agreement with the office's managed care contractor.

(e) Notwithstanding subsection (a), this section does not prohibit the office or the office's managed care contractor from directing individuals described in section 2 of this chapter to a hospital other than a hospital in a city where the patient resides if both of the following conditions exist:

(1) The patient is directed to a hospital other than a hospital in a city where the patient resides for the purpose of receiving medically necessary services.

(2) The type of medically necessary services to be received by the patient cannot be obtained in a hospital in a city where the patient resides.

(f) Actions taken after December 31, 2004, and before January 1, 2008, in accordance with this section are hereby declared legal and valid, as if IC 12-15-11.5-3 had not expired.

(g) This section expires April 1, 2006.

SECTION 2. IC 12-15-11.5-4.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE DECEMBER 30, 2004 (RETROACTIVE)]: **Sec. 4.2. (a) A hospital that:**

(1) does not have a contract in effect with the office's managed care contractor; but

(2) previously contracted or entered into an agreement with the office's managed care contractor for the provision of services under the office's managed care program;

shall be reimbursed for services provided to individuals described in section 2 of this chapter at rates equivalent to the rates negotiated under the hospital's most recent contract or agreement with the office's managed care contractor, as adjusted for inflation by the inflation adjustment factor described in subsection (b). However, the adjusted rates may not exceed the established Medicaid rates paid to Medicaid providers who are not contracted providers in the office's managed health care services program.

(b) For each state fiscal year beginning after June 30, 2001, an inflation adjustment factor shall be applied under subsection (a)

that is the average of the percentage increase in the medical care component of the Consumer Price Index for all Urban Consumers and the percentage increase in the Consumer Price Index for all Urban Consumers, as published by the United States Bureau of Labor Statistics, for the twelve (12) month period ending in March preceding the beginning of the state fiscal year.

(c) Actions taken after December 31, 2004, and before January 1, 2008, in accordance with this section are hereby declared legalized and valid, as if IC 12-15-11.5-4.1 had not expired.

(d) This section expires December 31, 2007.

SECTION 3. IC 12-15-12-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. (a) A Medicaid recipient may be admitted to a hospital by a physician other than the recipient's managed care provider if the recipient requires immediate medical treatment.

(b) The admitting physician shall notify the recipient's managed care provider of the recipient's admission not more than forty-eight (48) hours after the recipient's admission.

(c) Payment for services provided a recipient admitted to a hospital under this section shall be made only for services that the office or the contractor under IC 12-15-30 determines were medically reasonable and necessary.

(d) A physician who provides physician services in the emergency department of a hospital licensed under IC 16-21 to a recipient of services from a managed care organization shall notify the managed care organization not later than five (5) business days after the physician provided a service to the recipient. The managed care organization may specify the procedure by which the physician must notify the managed care organization, including that the notice may be in written or electronic format.

SECTION 4. IC 12-15-12-18.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 18.5. (a) Subject to federal law, a managed care organization may establish policies to control the inappropriate utilization of emergency room services by a recipient.**

(b) Before a managed care organization may implement a policy under subsection (a), the managed care organization shall notify each Medicaid recipient at least thirty (30) days before implementing the policy.

(c) A recipient may appeal under IC 4-21.5 the implementation of a policy under subsection (a).

SECTION 5. IC 12-15-15-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2.5. (a) Payment for physician services provided in the emergency department of a hospital licensed under IC 16-21 must be at a rate of one hundred percent (100%) of rates payable under the Medicaid fee structure.

(b) The payment under subsection (a) must be calculated using the same methodology used for all other physicians participating in the Medicaid program.

(c) For services rendered and documented in an individual's medical record, physicians must be reimbursed for federally required medical screening exams that are necessary to determine the presence of an emergency using the appropriate Current Procedural Terminology (CPT) codes 99281, 99282, or 99283 described in the Current Procedural Terminology Manual published annually by the American Medical Association, without authorization by the enrollee's primary medical provider.

(d) Payment for all other physician services provided in an emergency department of a hospital to enrollees in the Medicaid primary care case management program must be at a rate of one hundred percent (100%) of the Medicaid fee structure rates, provided the service is authorized, prospectively or retrospectively, by the enrollee's primary medical provider.

(e) This section does not apply to ~~a person enrolled in~~ the Medicaid risk based managed care program.

SECTION 6. IC 12-15-15-2.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 2.7. (a) This section applies to a physician who:**

(1) provides services in an emergency department of a hospital licensed under IC 16-21; and

(2) does not have a contract with a managed care organization.

(b) For services rendered and documented in an individual's medical record, physicians must be reimbursed for federally required medical screening exams that are necessary to determine the presence of an emergency using the appropriate Current Procedural Terminology (CPT) codes 99281, 99282, or 99283 described in the Current Procedural Terminology Manual published annually by the American Medical Association, without authorization by the enrollee's primary medical provider.

(c) A physician may agree to provide the services described in subsection (b) for:

(1) a negotiated rate other than one hundred percent (100%) of the rate payable under the Medicaid fee structure; or

(2) one hundred percent (100%) of the rate payable under the Medicaid fee structure.

SECTION 7. IC 12-16-2.5-6.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 6.3. For purposes of this article, the following definitions apply to the hospital care for the indigent program:**

(1) "Assistance" means the satisfaction of a person's financial obligation under IC 12-16-7.5-1.2 for hospital items or services, physician services, or transportation services provided to the person.

(2) "Claim" means a statement filed with the division by a hospital, physician, or transportation provider that identifies the health care items or services the hospital, physician, or transportation provider provided to a person for whom an application under IC 12-16-4.5 has been filed with the division.

(3) "Eligible" or "eligibility", when used in regard to a person for whom an application under IC 12-16-4.5 has been filed with the division, means the extent to which:

(A) the person, for purposes of the application, satisfies the income and resource standards established under IC 12-16-3.5; and

(B) the person's medical condition, for purposes of the application, satisfies one (1) or more of the medical conditions identified in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3).

SECTION 8. IC 12-16-2.5-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 6.5. (a) Notwithstanding IC 12-16-4.5, IC 12-16-5.5, and IC 12-16-6.5, except for the functions provided for under IC 12-16-4.5-3, IC 12-16-4.5-4, IC 12-16-6.5-3, IC 12-16-6.5-4, and IC 12-16-6.5-7, the division may enter into a written agreement with a hospital licensed under IC 16-21 for the hospital's performance of one (1) or more of the functions of the division or a county office under IC 12-16-4.5, IC 12-16-5.5, and IC 12-16-6.5. Under an agreement between the division and a hospital:**

(1) if the hospital is authorized to determine:

(A) if a person meets the income and resource requirements established under IC 12-16-3.5;

(B) if the person's medical condition satisfies one (1) or more of the medical conditions identified in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(C) if the health care items or services received by the person were necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3), or were a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

the determinations must be limited to persons receiving care at the hospital;

(2) the agreement must state whether the hospital is authorized to make determinations regarding physician services or transportation services provided to a person;

(3) the agreement must state the extent to which the functions performed by the hospital include the provision of the notices required under IC 12-16-5.5 and IC 12-16-6.5;

(4) the agreement may not limit the hearing and appeal process available to persons, physicians, transportation providers, or other hospitals under IC 12-16-6.5;

(5) the agreement must state how determinations made by the hospital will be communicated to the division for purposes of the attributions and calculations under IC 12-15-15-9, IC 12-15-15-9.5, IC 12-16-7.5, and IC 12-16-14; and

(6) the agreement must state how the accuracy of the hospital's determinations will be reviewed.

(b) A hospital, its employees, and its agents are immune from civil or criminal liability arising from their good faith implementation and administration of the agreement between the division and the hospital under this section.

SECTION 9. IC 12-16-3.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 1. (a) An Indiana resident who meets the income and resource standards established by the division under section 3 of this chapter is eligible for assistance to ~~pay for any part of the cost of~~ **satisfy the resident's financial obligation for** care provided **to the resident** in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of

immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of a bodily organ or part.

(b) A qualified resident is also eligible for assistance to ~~pay~~ **satisfy the resident's financial obligation** for the ~~part of the cost of~~ care that is a direct consequence of the medical condition that necessitated the emergency care.

SECTION 10. IC 12-16-3.5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 2. (a) An individual who is not an Indiana resident is eligible for assistance to ~~pay~~ **satisfy the individual's financial obligation** for the ~~part of the cost of~~ care provided **to the individual** in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(b) An individual is eligible for assistance under subsection (a) only if the following qualifications exist:

(1) The individual meets the income and resource standards established by the division under section 3 of this chapter.

(2) The onset of the medical condition that necessitated medical attention occurred in Indiana.

SECTION 11. IC 12-16-3.5-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. (a) The division shall adopt rules under IC 4-22-2 to establish income and resource eligibility standards for patients whose care is to be paid under the hospital care for the indigent program.

(b) To the extent possible **and subject to this article,** rules adopted under this section must meet the following conditions:

(1) Be consistent with IC 12-15-21-2 and IC 12-15-21-3.

(2) Be adjusted at least one (1) time every two (2) years.

(c) The income and eligibility standards established under this section do not include any spend down provisions available under IC 12-15-21-2 or IC 12-15-21-3.

(d) In addition to the conditions imposed under subsection (b), rules adopted under this section must exclude a Holocaust victim's settlement payment received by an eligible individual from the income

and eligibility standards for patients whose care is to be paid for under the hospital care for the indigent program.

SECTION 12. IC 12-16-4.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. (a) To receive ~~payment from the division for the care provided to an~~ **assistance under the hospital care for the** indigent ~~person,~~ **program under this article,** a hospital, **the person, or the person's representative** must file an application regarding the person with the division.

(b) Upon receipt of an application under subsection (a), the division shall determine whether the person is a resident of Indiana and, if so, the person's county of residence. If the person is a resident of Indiana, the division shall provide a copy of the application to the county office of the person's county of residence. If the person is not a resident of Indiana, the division shall provide a copy of the application to the county office of the county where the onset of the medical condition that necessitated the care occurred. If the division cannot determine whether the person is a resident of Indiana or, if the person is a resident of Indiana, the person's county of residence, the division shall provide a copy of the application to the county office of the county where the onset of the medical condition that necessitated the care occurred.

(c) A county office that receives a request from the division shall cooperate with the division in determining whether a person is a resident of Indiana and, if the person is a resident of Indiana, the person's county of residence.

SECTION 13. IC 12-16-4.5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. A hospital must file the application with the division not more than ~~thirty (30)~~ **forty-five (45)** days after the person has been ~~admitted to, or otherwise provided care by,~~ **released or discharged from** the hospital, unless the person is medically unable and the next of kin or legal representative is unavailable.

SECTION 14. IC 12-16-4.5-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. **Subject to this article,** the division shall adopt rules under IC 4-22-2 prescribing the following:

(1) The form of an application.

(2) The establishment of procedures for applications.

(3) The time for submitting and processing claims.

SECTION 15. IC 12-16-4.5-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. (a) A person may file an application directly with the division if the application is filed not more than ~~thirty (30)~~ **forty-five (45)** days after the person ~~was~~

~~admitted to, or provided care by,~~ **has been released or discharged from** the hospital.

(b) Reimbursement for the costs incurred in providing care to an eligible person may only be made to the providers of the care.

SECTION 16. IC 12-16-4.5-8.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 8.5. A claim for hospital items or services, physician services, or transportation services must be filed with the division not more than forty-five (45) days after the person who received the care has been released or discharged from the hospital. For good cause as determined by the division, this forty-five (45) day limit may be extended or waived for a claim.**

SECTION 17. IC 12-16-5.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. **(a)** The division shall, upon receipt of an application of or for a person who was admitted to, or who was otherwise provided care by, a hospital, promptly investigate to determine the person's eligibility under the hospital care for the indigent program. **The division shall consider the following information obtained by the hospital regarding the person:**

(1) Income.

(2) Resources.

(3) Place of residence.

(4) Medical condition.

(5) Hospital care.

(6) Physician care.

(7) Transportation to and from the hospital.

The division may rely on the hospital's information in determining the person's eligibility under the program.

(b) The division may choose not to interview the person if, based on the information provided to the division, the division determines that it appears that the person is eligible for the program. If the division determines that an interview of the person is necessary, the division shall allow the interview to occur by telephone with the person or with the person's representative if the person is not able to participate in the interview.

(c) The county office located in:

(1) the county where the person is a resident; or

(2) the county where the onset of the medical condition that necessitated the care occurred if the person's Indiana residency or Indiana county of residence cannot be determined;

shall cooperate with the division in determining the person's eligibility

under the program.

SECTION 18. IC 12-16-5.5-1.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.2. (a) The division shall, upon receipt of a claim pertaining to a person:**

(1) who was admitted to, or who was otherwise provided care by, a hospital; and

(2) whose medical condition satisfies one (1) or more of the medical conditions identified in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3);

promptly review the claim to determine if the health care items or services identified in the claim were necessitated by the person's medical condition or, if applicable, if the items or services were a direct consequence of the person's medical condition.

(b) In conducting the review of a claim referenced in subsection (a), the division shall calculate the amount of the claim. For purposes of this section, IC 12-15-15-9, IC 12-15-15-9.5, IC 12-16-6.5, and IC 12-16-7.5, the amount of a claim shall be calculated by applying the office's applicable Medicaid fee-for-service reimbursement rate to each of the items and services identified in the claim that are determined:

(1) to have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) to be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

SECTION 19. IC 12-16-5.5-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. (a) Subject to subsection (b), if the division is unable after prompt and diligent efforts to verify information contained in the application that is reasonably necessary to determine eligibility, the division may deny assistance under the hospital care for the indigent program. **The pending expiration of the period specified in IC 12-16-6.5-1.5 is not a valid reason for denying assistance under the hospital care for the indigent program.**

(b) Before denying assistance under the hospital care for the indigent program, the division must provide the person and the hospital written notice of:

(1) the specific information or verification needed to determine

eligibility; ~~and~~

~~(2) the date on which the application will be denied if the information or verification is not provided within ten (10) days after the date of the notice.~~

(2) the specific efforts undertaken to obtain the information or verification; and

(3) the statute or rule requiring the information or verification identified under subdivision (1).

(c) The division must provide the hospital a period of time, not less than ten (10) days beyond the deadline established under IC 12-16-6.5-1.5, to submit to the division information concerning the person's eligibility. If the division does not make a determination of the person's eligibility within ten (10) days after receiving the information under this subsection, the person is eligible without the division's determination for the hospital care for the indigent care program.

SECTION 20. IC 12-16-5.5-3.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 3.2. (a) Subject to subsection (b), if the division is unable after prompt and diligent efforts to determine that a health care item or service identified in a claim:**

(1) was necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) was a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

the division may deny assistance to the person under the hospital care for the indigent program for that item or service. The pending expiration of the period specified in IC 12-16-6.5-1.7 is not a valid reason for determining that an item or a service was not necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3), or was not a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(b) Before denying assistance under the hospital care for the indigent program for an item or a service described in subsection (a), the division must provide the provider of the item or service written notice of:

(1) the specific item or service in question; and

(2) an explanation of the basis for the division's inability to determine that the health care item or service was:

(A) necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(B) a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

including, if applicable, an explanation of the basis for a conclusion by the division that an item or service, in fact, was not necessitated by, or, as applicable, not a direct consequence of, one (1) or more of such medical conditions.

(c) The division must grant the provider of the item or service a period of time, not less than ten (10) days beyond the deadline under IC 12-16-6.5-1.7, to submit to the division information or materials bearing on whether the item or service was necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3), or was a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3). If the division does not make its determination regarding the item or service within ten (10) days after receiving information or materials provided for in this section, the item or service is considered, without the division's determination, to have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3) or to have been a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

SECTION 21. IC 12-16-6.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. If the division determines that a person is not eligible for ~~payment of~~ **assistance for** medical care, hospital care, or transportation services, an affected person, physician, hospital, or transportation provider may appeal to the division not later than ninety (90) days after the mailing of notice of that determination to the affected person, physician, hospital, or transportation provider ~~at~~ **to** the last known address of the person, physician, hospital, or transportation provider.

SECTION 22. IC 12-16-6.5-1.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE UPON PASSAGE]: **Sec. 1.2. (a) If the division determines that an item or service identified in a claim:**

(1) was not necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) was not a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

the affected person, physician, hospital, and transportation provider may appeal to the division not later than ninety (90) days after the mailing of the notice of that determination to the affected person, physician, hospital, or transportation provider to the last known address of the person, physician, hospital, or transportation provider.

(b) If the division determines that an item or service identified in a claim:

(1) was necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) was a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

but the affected physician, hospital, or transportation provider disagrees with the amount of the claim calculated by the division under IC 12-16-5.5-1.2(b), the affected physician, hospital, or transportation provider may appeal the calculation to the division not later than ninety (90) days after the mailing of the notice of that calculation to the affected physician, hospital, or transportation provider to the last known address of the physician, hospital, or transportation provider.

SECTION 23. IC 12-16-6.5-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.5. Subject to IC 12-16-5.5-3(c), if the division fails to complete an investigation and determination of a person's eligibility for the hospital care for the indigent program not later than forty-five (45) days after receipt of the application filed under IC 12-16-4.5, the person is considered to be eligible without the division's determination for assistance under the program.**

SECTION 24. IC 12-16-6.5-1.7 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.7. Subject to IC 12-16-5.5-3.2(c) if the division fails to complete an investigation and determination of one (1) or more health care items or services identified in a claim within forty-five (45) days after receipt of the claim filed under IC 12-16-4.5, without the division's determination the item or service is considered to have been:**

(1) necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

SECTION 25. IC 12-16-6.5-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. (a) **If the division receives an application that was filed on behalf of a person under IC 12-16-4.5,** the division shall determine:

(1) the eligibility of the person for ~~payment of the cost of medical or hospital care~~ **assistance** under the hospital care for the indigent program; **and**

(2) if the health care items or services provided to the person and identified in a claim filed with the division under IC 12-16-4.5 were:

(A) necessitated by at least one (1) medical condition listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(B) the direct consequence of at least one (1) of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(b) If:

(1) the person is found eligible ~~the division shall pay the reasonable cost of the care covered under IC 12-16-3.5-1 or IC 12-16-3.5-2 to the physicians furnishing the covered medical care and the transportation providers furnishing the covered transportation services, subject to the limitations in IC 12-16-7.5.~~ **for assistance; and**

(2) at least one (1) of the items or services identified in the claim is determined:

(A) to have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(B) to be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

the person is entitled to assistance for those items and services.

~~(c) If the person is found eligible, the payment for the hospital services and items covered under IC 12-16-3.5-1 or IC 12-16-3.5-2 shall be calculated using the office's applicable Medicaid fee-for-service reimbursement principles. Payment to the hospital shall be made:~~

~~(1) under IC 12-15-15-9; and~~

~~(2) if the hospital is eligible, under IC 12-15-15-9.5.~~

SECTION 26. IC 12-16-6.5-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. A person, **hospital, physician, or transportation provider** aggrieved by a determination **of an appeal taken** under ~~section 5(a)~~ **section 1 or 1.2** of this chapter may appeal the determination under IC 4-21.5.

SECTION 27. IC 12-16-7.5-1.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 1.2. (a) A person determined to be eligible under the hospital care for the indigent program is not financially obligated for hospital items or services, physician services, or transportation services provided to the person during the person's eligibility under the program, if the items or services were:**

(1) identified in a claim filed with the division under IC 12-16-4.5; and

(2) determined:

(A) to have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(B) to be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(b) Based on a hospital's items or services identified in a claim under subsection (a), the hospital may receive a payment from the office calculated and made under IC 12-15-15-9 and IC 12-15-15-9.5.

(c) Based on a physician's services identified in a claim under subsection (a), the physician may receive a payment from the division calculated and made under section 5 of this chapter.

(d) Based on the transportation services identified in a claim under subsection (a), the transportation provider may receive a payment from the division calculated and made under section 5 of this chapter.

SECTION 28. IC 12-16-7.5-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 2.5. (a) **This section applies to payable claims involving:**

(1) hospital services or items;

(2) physician services; or

(3) transportation services;

provided before July 1, 2004.

(b) Payable claims shall be segregated by state fiscal year.

~~(b)~~ **(c)** For purposes of this chapter, IC 12-15-15-9, IC 12-15-15-9.5, and IC 12-16-14:

(1) a "payable claim" is a claim for payment for physician care, hospital care, or transportation services under this chapter:

(A) that includes, on forms prescribed by the division, all the information required for timely payment;

(B) that is for a period during which the person is determined to be financially and medically eligible for the hospital care for the indigent program; and

(C) for which the payment amounts for the care and services are determined by the division; and

(2) a physician, hospital, or transportation provider that submits a payable claim to the division is considered to have submitted the payable claim during the state fiscal year during which the division determined, initially or upon appeal, the amount to pay for the care and services comprising the payable claim.

~~(c)~~ **(d)** The division shall promptly determine the amount to pay for the care and services comprising a payable claim.

SECTION 29. IC 12-16-7.5-2.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 2.7. (a) Except as provided in subsection (f), this section applies to state fiscal years beginning after June 30, 2004.**

(b) For purposes of this chapter, IC 12-15-15-9, IC 12-15-15-9.5, and IC 12-16-14, the following definitions apply:

(1) "Amount" refers to a payable claim in an amount calculated under STEP THREE of the following formula:

STEP ONE: Identify the items and services comprising a payable claim.

STEP TWO: Using the applicable Medicaid fee for service

reimbursement rates, calculate the reimbursement amounts for each of the items and services identified in STEP ONE.

STEP THREE: Calculate the sum of the amounts identified in STEP TWO.

(2) "Payable claim" means a claim for hospital items or services, physician care, or transportation services:

(A) provided to a person under the hospital care for the indigent program under this article during the person's eligibility under the program;

(B) identified in a claim filed with the division; and

(C) determined to:

(i) have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(ii) to be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(c) Payable claims shall be segregated by state fiscal year.

(d) The division shall calculate the amount of a payable claim at the time referenced in IC 12-16-5.5-1.2.

(e) A physician, hospital, or transportation provider that submits a payable claim to the division is considered to have submitted the payable claim during the state fiscal year during which the division determined, initially or upon appeal, the amount of a payable claim.

(f) Hospital items or services, physician care, or transportation services provided between July 1, 2003, and June 30, 2004, are governed by section 2.5 of this chapter.

SECTION 30. IC 12-16-7.5-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 12. All providers receiving payment under **section 1.2 of** this chapter agree to accept, as payment in full, the ~~amount paid for the hospital care for the indigent program~~ **payment referred to in section 1.2 of this chapter** for ~~those claims submitted for payment under the program, with the exception of authorized deductibles, co-insurance, co-payment, or similar cost-sharing charges.~~ **the health care items or services identified in payable claims submitted to the division.**

SECTION 31. IC 12-16-12.5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. The division is responsible for the emergency medical care given in a hospital to an

individual who qualifies for assistance under this chapter, subject to ~~the limitations in~~ IC 12-16-7.5.

SECTION 32. IC 12-16-12.5-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) If a hospital owned by the health and hospital corporation is:

(1) unable to care for a patient; or

(2) unable to treat a patient at the time a transfer is requested by the hospital initiating treatment;

the hospital may continue to treat the patient until the patient's discharge.

(b) Subject to ~~the limitations in~~ IC 12-16-7.5, the division shall ~~pay the costs of~~ **be responsible for** care.

SECTION 33. IC 12-16-12.5-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. The ~~division is not responsible~~ **hospital care** for **the indigent program under this article does not apply to** the following:

(1) ~~The payment of~~ Nonemergency ~~medical costs,~~ **care,** except as provided under ~~the hospital care for the indigent program.~~ **this article.**

(2) ~~The payment of medical costs accrued~~ **Care provided** at a hospital owned or operated by a health and hospital corporation, except for ~~hospital~~ care provided under this chapter to a person not residing in Marion County.

SECTION 34. IC 12-16-14-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 3. (a) For purposes of this section, **the following definitions apply:**

(1) "Amount" ~~"payable claim"~~ has the meaning set forth in ~~IC 12-16-7.5-2.5(b)(1).~~ **IC 12-16-7.5-2.7(b)(1).**

(2) "Payable claim" has the meaning set forth in IC 12-16-7.5-2.7(b)(2).

(b) For taxes first due and payable in 2003, each county shall impose a hospital care for the indigent property tax levy equal to the product of:

(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in 2002; multiplied by

(2) the county's assessed value growth quotient determined under IC 6-1.1-18.5-2 for taxes first due and payable in 2003.

(c) For taxes first due and payable in 2004, 2005, ~~and~~ 2006, **2007, and 2008,** each county shall impose a hospital care for the indigent property tax levy equal to the product of:

(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in the preceding year; multiplied by

(2) the assessed value growth quotient determined in the last STEP of the following STEPS:

STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective.

STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.

STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).

(d) Except as provided in subsection (e):

(1) for taxes first due and payable in ~~2007,~~ **2009,** each county shall impose a hospital care for the indigent property tax levy equal to the average **of the** annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the state fiscal years beginning:

~~(A) July 1, 2003;~~

~~(B) July 1, 2004; and~~

~~(C)~~ **(A)** July 1, 2005; ~~and~~

(B) July 1, 2006; and

(C) July 1, 2007; and

(2) for all subsequent annual levies under this section, the average annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the three (3) most recently completed state fiscal years.

(e) A county may not impose an annual levy under subsection (d) in an amount greater than the product of:

(1) The greater of:

(A) the county's hospital care for the indigent property tax levy for taxes first due and payable in ~~2006,~~ **2008;** or

(B) the amount of the county's maximum hospital care for the indigent property tax levy determined under this subsection for taxes first due and payable in the immediately preceding year; multiplied by

(2) the assessed value growth quotient determined in the last STEP of the following STEPS:

STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a

statewide general reassessment of real property does not first become effective.

STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.

STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).

(f) For purposes of this section, a payable claim is attributed to the state fiscal year during which the division determined, initially or upon appeal, the amount of the payable claim.

SECTION 35. IC 29-2-16-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 1. Except where the context clearly indicates a different meaning, the terms used in this chapter shall be construed as follows:

(a) "Bank or storage facility" means a facility licensed, accredited, or approved under the laws of any state for storage of human bodies or parts thereof.

(b) "Decedent" means a deceased individual and includes a stillborn infant or fetus.

(c) "Donor" means an individual who makes a gift of all or part of ~~his~~ **the decedent's** body.

(d) "Hospital" means a hospital licensed, accredited, or approved under the laws of any state. **The term** includes a hospital operated by the United States government, a state, or a subdivision thereof, although not required to be licensed under state laws.

(e) "Part" means organs, tissues, eyes, bones, arteries, blood, other fluids, and any other portions of a human body.

(f) "Person" means an individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

(g) "Physician" or "surgeon" means a physician or surgeon licensed or authorized to practice under the laws of any state.

(h) "Procurement organization" means an organization qualified to recover anatomical gifts from donors.

~~(h)~~ **(i)** "State" includes any state, district, commonwealth, territory, insular possession, and any other area subject to the legislative authority of the United States of America.

SECTION 36. IC 29-2-16-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 3. The following

persons may become donees of gifts of bodies or parts thereof for the purposes stated:

(1) any hospital, surgeon, or physician for medical or dental education, research, advancement of medical or dental science, therapy, or transplantation; ~~or~~

(2) any accredited medical or dental school, college or university for education, research, advancement of medical or dental science, or therapy; ~~or~~

(3) any ~~bank~~ **procurement organization** or storage facility, for medical or dental education, research, advancement of medical or dental science, therapy, or transplantation; or

(4) any specified individual for therapy or transplantation needed by ~~him.~~ **the individual.**

SECTION 37. IC 29-2-16-4.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 4.5. (a) A coroner ~~may release and permit~~ **shall attempt to facilitate permission for** the removal of ~~a part from a body~~ **organs, tissues, or eyes** within the coroner's custody, for transplantation, ~~or~~ therapy, ~~only,~~ **or research by providing information to or seeking information from the procurement organization that would assist the procurement organization in the evaluation of the viability for transplantation of any organ, tissue, or eye** if all of the following occur:

(1) The coroner receives a request ~~for a part~~ from a hospital, physician, surgeon, or procurement organization.

(2) The coroner makes a reasonable effort, taking into account the useful life of a part, to locate and examine the decedent's medical records and inform individuals listed in section 2(b) of this chapter of their option to make or object to making a gift under this chapter.

(3) The decision to allow the removal of organs, tissues, or eyes is based on a medical decision made by the pathologist or forensic pathologist. If the pathologist or forensic pathologist considers withholding one (1) or more organs or tissues of a potential donor, the pathologist or forensic pathologist:

(A) shall be present during the removal of the organs or tissues;

(B) may request a biopsy of the removed organs; and

(C) after viewing the removed organs or tissues and determining that removal may interfere with the death investigation, may prohibit removal and shall provide a written explanation to the procurement organization.

If it is determined that prior removal will interfere with the

death investigation, the procurement organization may remove the tissues and eyes after the autopsy.

~~(3)~~ **(4)** The coroner does not know of a refusal or contrary indication by the decedent or an objection by an individual having priority to act as listed in section 2(b) of this chapter.

~~(4)~~ **(5)**The removal will be by:

(A) a physician licensed under IC 25-22.5; or

(B) in the case of removal of an eye or part of an eye, by an individual described in section 4(e) of this chapter; and under IC 36-2-14-19.

~~(5)~~ **(6)** The removal will not interfere with any autopsy or investigation.

~~(6)~~ **(7)** The removal will be in accordance with accepted medical standards.

~~(7)~~ **(8)** Cosmetic restoration will be done, if appropriate.

(9) If the pathologist or forensic pathologist is required to be present to examine the decedent before or during the removal of the parts, the procurement organization shall reimburse the pathologist or forensic pathologist for actual costs, but the amount may not exceed one thousand dollars ($1,000). The county is not responsible for any costs incurred by the pathologist, forensic pathologist, or procurement organization under this subdivision.

(10) If requested by the coroner, pathologist, or forensic pathologist, the procurement organization shall provide a surgeon's report detailing the condition of the organs and the relationship of the organs to the cause of death, if any.

(b) If the body is not within the custody of the coroner, the ~~medical examiner~~ **pathologist or forensic pathologist** may release and permit the removal of any part from a body ~~in the medical examiner's custody~~ for transplantation or therapy if the requirements of subsection (a) are met.

(c) A person under this section who releases or permits the removal of a part shall maintain a permanent record of the name of the decedent, the individual making the request, the date and purpose of the request, the body part requested, and the person to whom it was released.

SECTION 38. IC 29-2-16-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 6.5. (a) Except for a gift made by a donor to a specific donee, a procurement organization that holds an agreement with a hospital to perform anatomical gift donation**

services for the hospital under 42 U.S.C. 1329b-8 and 42 CFR Part 482 is considered to be the donee of all gifts from patients who have died in the hospital.

(b) An investigation by a coroner or a medical examiner does not change the rights of a procurement organization to act as the donee.

SECTION 39. IC 34-30-2-45.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 45.2. IC 12-16-2.5-6.5 (Concerning administering agreements between the hospital and the division of family and children under the hospital care for the indigent program).**

SECTION 40. THE FOLLOWING ARE REPEALED [EFFECTIVE DECEMBER 31, 2004 (RETROACTIVE)]: IC 12-15-11.5-3; IC 12-15-11.5-4.1.

SECTION 41. THE FOLLOWING ARE REPEALED [EFFECTIVE UPON PASSAGE]: IC 12-16-2.5-3; IC 12-16-6.5-2; IC 12-16-7.5-1; IC 12-16-11.5-1; IC 12-16-11.5-2.

SECTION 42. **An emergency is declared for this act.**

SENATE MOTION

Madam President: I move that Senator Garton be removed as author of Senate Bill 66 and that Senator Dillon be substituted therefor.

GARTON

COMMITTEE REPORT

Madam President: The Senate Committee on Rules and Legislative Procedure, to which was referred Senate Bill No. 66, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning health.

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill be reassigned to the Senate Committee on Health and Provider Services.

(Reference is to SB 66 as introduced.)

GARTON, Chairperson

SENATE MOTION

Madam President: I move that Senator Rogers be added as coauthor of Senate Bill 66.

DILLON

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 66, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill DO PASS.

(Reference is made to Senate Bill 66 as printed February 16, 2005.)

MILLER, Chairperson

Committee Vote: Yeas 10, Nays 0.

SENATE MOTION

Madam President: I move that Senate Bill 66 be amended to read as follows:

Page 3, between lines 10 and 11, begin a new paragraph and insert:

"SECTION 3. IC 12-16-4.5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. A hospital must file the application with the division not more than ~~thirty (30)~~ **forty-five (45)** days after the person has been admitted to, or otherwise provided care by, **released or discharged from** the hospital, unless the person is medically unable and the next of kin or legal representative is unavailable.

SECTION 4. IC 12-16-7.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. The division shall pay the following **under IC 12-16-9.5 and** subject to the limitations in section 5 of this chapter:

(1) The reasonable cost of ~~medical~~ **physician** care covered under IC 12-16-3.5-1 or IC 12-16-3.5-2.

(2) The reasonable cost of transportation ~~to the place of treatment arising out of the medical care.~~ **where health care services covered under IC 12-16-3.5-1 or IC 12-16-3.5-2 are provided.**

SECTION 5. IC 12-16-7.5-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 2.5. (a) **This section applies to payable claims involving:**

(1) hospital services or items;

(2) physician care; or

(3) transportation services;

provided before July 1, 2004.

(b) Payable claims shall be segregated by state fiscal year.

~~(b)~~**(c)** For purposes of this chapter, IC 12-15-15-9, IC 12-15-15-9.5,

and IC 12-16-14:

(1) a "payable claim" is a claim for payment for physician care, hospital care, or transportation services under this chapter:

(A) that includes, on forms prescribed by the division, all the information required for timely payment;

(B) that is for a period during which the person is determined to be financially and medically eligible for the hospital care for the indigent program; and

(C) for which the payment amounts for the care and services are determined by the division; and

(2) a physician, hospital, or transportation provider that submits a payable claim to the division is considered to have submitted the payable claim during the state fiscal year during which the division determined, initially or upon appeal, the amount to pay for the care and services comprising the payable claim.

~~(c)~~**(d)** The division shall promptly determine the amount to pay for the care and services comprising a payable claim.".

Renumber all SECTIONS consecutively.

(Reference is to SB 66 as reprinted February 25, 2005.)

DILLON

SENATE MOTION

Madam President: I move that Senator Smith S be added as coauthor of Engrossed Senate Bill 66.

DILLON

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 66, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 3, between lines 10 and 11, begin a new paragraph and insert:

"SECTION 3. IC 12-15-15-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2.5. (a) Payment for physician services provided in the emergency department of a hospital

licensed under IC 16-21 must be at a rate of one hundred percent (100%) of rates payable under the Medicaid fee structure.

(b) The payment under subsection (a) must be calculated using the same methodology used for all other physicians participating in the Medicaid program.

(c) For services rendered and documented in an individual's medical record, physicians must be reimbursed for federally required medical screening exams that are necessary to determine the presence of an emergency using the appropriate Current Procedural Terminology (CPT) codes 99281, 99282, or 99283 described in the Current Procedural Terminology Manual published annually by the American Medical Association, without authorization by the enrollee's primary medical provider.

(d) Payment for all other physician services provided in an emergency department of a hospital to enrollees in the Medicaid primary care case management program must be at a rate of one hundred percent (100%) of the Medicaid fee structure rates, provided the service is authorized, prospectively or retrospectively, by the enrollee's primary medical provider.

~~(e) This section does not apply to a person enrolled in the Medicaid risk based managed care program.~~

SECTION 4. IC 12-16-2.5-6.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 6.3. For purposes of this article, the following definitions apply to the hospital care for the indigent program:**

(1) "Assistance" means the satisfaction of a person's financial obligation for hospital items or services, physician services, or transportation services provided to the person under IC 12-16-7.5-1.2.

(2) "Claim" means a statement filed with the division by a hospital, physician, or transportation provider that identifies the health care items or services the hospital, physician, or transportation provider provided to a person for whom an application under IC 12-16-4.5 has been filed with the division.

(3) "Eligible" or "eligibility", when used in regard to a person for whom an application under IC 12-16-4.5 has been filed with the division, means the extent to which:

(A) the person, for purposes of the application, satisfies the income and resource standards established under IC 12-16-3.5; and

(B) the person's medical condition, for purposes of the application, satisfies one (1) or more of the medical conditions identified in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3).

SECTION 5. IC 12-16-2.5-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 6.5. (a) Notwithstanding IC 12-16-4.5, IC 12-16-5.5, and IC 12-16-6.5, except for the functions provided for under IC 12-16-4.5-3, IC 12-16-4.5-4, IC 12-16-6.5-3, IC 12-16-6.5-4, and IC 12-16-6.5-7, the division may enter into a written agreement with a hospital licensed under IC 16-21 for the hospital's performance of one (1) or more of the functions of the division or a county office under IC 12-16-4.5, IC 12-16-5.5, and IC 12-16-6.5. Under an agreement between the division and a hospital:**

(1) if the hospital is authorized to determine:

(A) if a person meets the income and resource requirements established under IC 12-16-3.5;

(B) if the person's medical condition satisfies one (1) or more of the medical conditions identified in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(C) if the health care items or services received by the person were necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3), or were a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

the determinations must be limited to persons receiving care at the hospital;

(2) the agreement must state whether the hospital is authorized to make determination regarding physician services or transportation services provided to a person;

(3) the agreement must state the extent to which the functions performed by the hospital include the provision of the notices required under IC 12-16-5.5 and IC 12-16-6.5;

(4) the agreement may not limit the hearing and appeal process available to persons, physicians, transportation providers, or other hospitals under IC 12-16-6.5;

(5) the agreement must state how determinations made by the

hospital will be communicated to the division for purposes of the attributions and calculations under IC 12-15-15-9, IC 12-15-15-9.5, IC 12-16-7.5, and IC 12-16-14; and

(6) the agreement must state how the accuracy of the hospital's determinations will be reviewed.

(b) A hospital, its employees, and its agents are immune from civil or criminal liability arising from their good faith implementation and administration of the agreement between the division and the hospital under this section.

SECTION 6. IC 12-16-3.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 1. (a) An Indiana resident who meets the income and resource standards established by the division under section 3 of this chapter is eligible for assistance to ~~pay for any part of the cost of~~ **satisfy the resident's financial obligation for** care provided **to the resident** in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of a bodily organ or part.

(b) A qualified resident is also eligible for assistance to ~~pay~~ **satisfy the resident's financial obligation** for the ~~part of the cost of~~ care that is a direct consequence of the medical condition that necessitated the emergency care.

SECTION 7. IC 12-16-3.5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 2. (a) An individual who is not an Indiana resident is eligible for assistance to ~~pay~~ **satisfy the resident's financial obligation** for the ~~part of the cost of~~ care provided **to the individual** in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(b) An individual is eligible for assistance under subsection (a) only if the following qualifications exist:

(1) The individual meets the income and resource standards established by the division under section 3 of this chapter.

(2) The onset of the medical condition that necessitated medical attention occurred in Indiana.

SECTION 8. IC 12-16-3.5-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. (a) The division shall adopt rules under IC 4-22-2 to establish income and resource eligibility standards for patients whose care is to be paid under the hospital care for the indigent program.

(b) To the extent possible **and subject to this article,** rules adopted under this section must meet the following conditions:

(1) Be consistent with IC 12-15-21-2 and IC 12-15-21-3.

(2) Be adjusted at least one (1) time every two (2) years.

(c) The income and eligibility standards established under this section do not include any spend down provisions available under IC 12-15-21-2 or IC 12-15-21-3.

(d) In addition to the conditions imposed under subsection (b), rules adopted under this section must exclude a Holocaust victim's settlement payment received by an eligible individual from the income and eligibility standards for patients whose care is to be paid for under the hospital care for the indigent program.

SECTION 9. IC 12-16-4.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. (a) To receive ~~payment from the division for the care provided to an~~ **assistance under the hospital care for the** indigent ~~person,~~ **program under this article,** a hospital, **the person, or the person's representative** must file an application regarding the person with the division.

(b) Upon receipt of an application under subsection (a), the division shall determine whether the person is a resident of Indiana and, if so, the person's county of residence. If the person is a resident of Indiana, the division shall provide a copy of the application to the county office of the person's county of residence. If the person is not a resident of Indiana, the division shall provide a copy of the application to the county office of the county where the onset of the medical condition that necessitated the care occurred. If the division cannot determine whether the person is a resident of Indiana or, if the person is a resident of Indiana, the person's county of residence, the division shall provide a copy of the application to the county office of the county where the onset of the medical condition that necessitated the care occurred.

(c) A county office that receives a request from the division shall cooperate with the division in determining whether a person is a resident of Indiana and, if the person is a resident of Indiana, the person's county of residence.".

Page 3, line 14, strike "admitted to, or otherwise".

Page 3, line 15, strike "provided care by,".

Page 3, between lines 17 and 18, begin a new paragraph and insert:

"SECTION 11. IC 12-16-4.5-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. **Subject to this article,** the division shall adopt rules under IC 4-22-2 prescribing the following:

(1) The form of an application.

(2) The establishment of procedures for applications.

(3) The time for submitting and processing claims.

SECTION 12. IC 12-16-4.5-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. (a) A person may file an application directly with the division if the application is filed not more than ~~thirty (30)~~ **forty-five (45)** days after the person ~~was admitted to, or provided care by,~~ **has been released or discharged from** the hospital.

(b) Reimbursement for the costs incurred in providing care to an eligible person may only be made to the providers of the care.

SECTION 13. IC 12-16-4.5-8.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 8.5. A claim for hospital items or services, physician services, or transportation services must be filed with the division not more than forty-five (45) days after the person who received the care has been released or discharged from the hospital. For good cause as determined by the division, this forty-five (45) day limit may be extended or waived for a claim.**

SECTION 14. IC 12-16-5.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. **(a)** The division shall, upon receipt of an application of or for a person who was admitted to, or who was otherwise provided care by, a hospital, promptly investigate to determine the person's eligibility under the hospital care for the indigent program. **The division shall consider the following information obtained by the hospital regarding the person:**

(1) Income.

(2) Resources.

(3) Place of residence.

(4) Medical condition.

(5) Hospital care.

(6) Physician care.

(7) Transportation to and from the hospital.

The division may rely on the hospital's information in determining the person's eligibility under the program.

(b) The division may choose not to interview the person if, based on the information provided to the division, the division determines that it appears that the person is eligible for the program. If the division determines that an interview of the person is necessary, the division shall allow the interview to occur by telephone with the person or the person's representative if the person is not able to participate in the interview.

(c) The county office located in:

(1) the county where the person is a resident; or

(2) the county where the onset of the medical condition that necessitated the care occurred if the person's Indiana residency or Indiana county of residence cannot be determined;

shall cooperate with the division in determining the person's eligibility under the program.

SECTION 15. IC 12-16-5.5-1.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.2. (a) The division shall, upon receipt of a claim pertaining to a person:**

(1) who was admitted to, or who was otherwise provided care by, a hospital; and

(2) whose medical condition satisfies one (1) or more of the medical conditions identified in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3);

promptly review the claim to determine if the health care items or services identified in the claim were necessitated by the person's medical condition or, if applicable, if the items or services were a direct consequence of the person's medical condition.

(b) In conducting the review of a claim referenced in subsection (a), the division shall calculate the amount of the claim. For purposes of this section, IC 12-15-15-9, IC 12-15-15-9.5, IC 12-16-6.5, and IC 12-16-7.5, the amount of a claim shall be calculated by applying the office's applicable Medicaid fee-for-service reimbursement rate to each of the items and services identified in the claim that are determined:

(1) to have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) to be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

SECTION 16. IC 12-16-5.5-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. (a) Subject to subsection (b), if the division is unable after prompt and diligent efforts to verify information contained in the application that is reasonably necessary to determine eligibility, the division may deny assistance under the hospital care for the indigent program. **The pending expiration of the period specified in IC 12-16-6.5-1.5 is not a valid reason for denying assistance under the hospital care for the indigent program.**

(b) Before denying assistance under the hospital care for the indigent program, the division must provide the person and the hospital written notice of:

(1) the specific information or verification needed to determine eligibility; ~~and~~

~~(2) the date on which the application will be denied if the information or verification is not provided within ten (10) days after the date of the notice.~~

(2) the specific efforts undertaken to obtain the information or verification; and

(3) the statute or rule requiring the information or verification identified under subdivision (1).

(c) The division must provide the hospital at least ten (10) days beyond the deadline established under IC 12-16-6.5-1.5 to provide the division with information concerning the person's eligibility. If the division does not make a determination of the person's eligibility within ten (10) days after receiving the information under this subsection, the person is eligible for the hospital care for the indigent care program.

SECTION 17. IC 12-16-5.5-3.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 3.2. (a) Subject to subsection (b), if the division is unable to determine that a health care item or service identified in a claim:**

(1) was necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) was a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

the division may deny assistance to the person under the hospital care for the indigent program for that item or service. The pending

expiration of the period specified in IC 12-16-6.5-1.7 is not a valid reason for determining that an item or a service was not necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3), or was not a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(b) Before denying assistance under the hospital care for the indigent program for an item or a service described in subsection (a), the division must provide the provider of the item or service written notice of:

(1) the specific item or service in question; and

(2) an explanation of the basis for the division's inability to determine that the health care item or service was:

(A) necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(B) a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

including, if applicable, an explanation of the basis for a conclusion by the division that the item or service, in fact, was not necessitated by, or, as applicable, not a direct consequence of, one (1) or more of such medical conditions.

The division must grant the provider of the item or service time to provide the division with information or materials bearing on whether the item or service was necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3), or a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3), but time granted by the division may not be less than ten (10) days beyond the deadline established under IC 12-16-6.5-1.7. If the division does not make its determination regarding the item or service within ten (10) days after receiving information or materials provided for in this section, the item or service is considered to have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3), or a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through

IC 12-16-3.5-1(a)(3).

SECTION 18. IC 12-16-6.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. If the division determines that a person is not eligible for ~~payment of~~ **assistance for** medical care, hospital care, or transportation services, an affected person, physician, hospital, or transportation provider may appeal to the division not later than ninety (90) days after the mailing of notice of that determination to the affected person, physician, hospital, or transportation provider ~~at~~ **to** the last known address of the person, physician, hospital, or transportation provider.

SECTION 19. IC 12-16-6.5-1.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.2. (a) If the division determines that an item or service identified in a claim:**

(1) was not necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) was not a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

the affected person, physician, hospital, and transportation provider may appeal to the division not later than ninety (90) days after the mailing of the notice of that determination to the affected person, physician, hospital, or transportation provider to the last known address of the person, physician, hospital, or transportation provider.

(b) If the division determines that an item or service identified in a claim:

(1) was necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) was a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

but the affected physician, hospital, or transportation provider disagrees with the amount of the claim calculated by the division under IC 12-16-5.5-1.2(b), the affected physician, hospital, or transportation provider may appeal the calculation to the division not later than ninety (90) days after the mailing of the notice of that calculation to the affected physician, hospital, or

transportation provider to the last known address of the physician, hospital, or transportation provider.

SECTION 20. IC 12-16-6.5-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.5. Subject to IC 12-16-5.5-3(c), if the division fails to complete an investigation and determination of a person's financial and medical eligibility for the hospital care for the indigent program not later than forty-five (45) days after receipt of the application filed under IC 12-16-4.5, the person is considered to be eligible for assistance under the program.**

SECTION 21. IC 12-16-6.5-1.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.7. Subject to IC 12-16-5.5-3.2(b), if the division fails to complete an investigation and determination of one (1) or more health care items or services identified in a claim within forty-five (45) days after receipt of the claim filed under IC 12-16-4.5, the item or service is considered to have been:**

(1) necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

SECTION 22. IC 12-16-6.5-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. (a) **If the division receives an application that was filed on behalf of a person under IC 12-16-4.5,** the division shall determine:

(1) the eligibility of the person for ~~payment of the cost of medical or hospital care~~ **assistance** under the hospital care for the indigent program; **and**

(2) if the health care items or services provided to the person and identified in a claim filed with the division under IC 12-16-4.5 were:

(A) necessitated by at least one (1) medical condition listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(B) the direct consequence of at least one (1) of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(b) If:

(1) the person is found eligible ~~the division shall pay the reasonable cost of the care covered under IC 12-16-3.5-1 or IC 12-16-3.5-2 to the physicians furnishing the covered medical care and the transportation providers furnishing the covered transportation services, subject to the limitations in IC 12-16-7.5.~~ **for assistance; and**

(2) at least one (1) of the items or services identified in the claim is determined:

(A) to have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(B) to be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

the person must receive assistance for those items and services.

~~(c) If the person is found eligible, the payment for the hospital services and items covered under IC 12-16-3.5-1 or IC 12-16-3.5-2 shall be calculated using the office's applicable Medicaid fee-for-service reimbursement principles. Payment to the hospital shall be made:~~

~~(1) under IC 12-15-15-9; and~~

~~(2) if the hospital is eligible, under IC 12-15-15-9.5.~~

SECTION 23. IC 12-16-6.5-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. A person, **hospital, physician, or transportation provider** aggrieved by a determination **of an appeal taken** under ~~section 5(a)~~ **section 1 or 1.2** of this chapter may appeal the determination under IC 4-21.5.".

Page 3, delete lines 18 through 26, begin a new paragraph and insert:

"SECTION 24. IC 12-16-7.5-1.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 1.2. (a) A person determined to be eligible under the hospital care for the indigent program is not financially obligated for hospital items or services, physician services, or transportation services provided to the person during the person's eligibility under the program, if the items or services were:**

(1) identified in a claim filed with the division under IC 12-16-4.5; and

(2) determined:

(A) to have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(B) to be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(b) Based on a hospital's items or services identified in a claim under subsection (a), the hospital must receive a payment from the office calculated and made under IC 12-15-15-9 and IC 12-15-15-9.5.

(c) Based on a physician's services identified in a claim under subsection (a), the physician must receive a payment from the division calculated and made under section 5 of this chapter.

(d) Based on the transportation services identified in a claim under in subsection (a), the transportation provider must receive a payment from the division calculated and made under section 5 of this chapter.".

Page 3, line 31, delete "care;" and insert "**services;**".

Page 4, between lines 10 and 11, begin a new paragraph and insert:

"SECTION 26. IC 12-16-7.5-2.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 2.7. (a) Except as provided in subsection (f), this section applies to state fiscal years beginning after June 30, 2004.**

(b) For purposes of this chapter, IC 12-15-15-9, IC 12-15-15-9.5, and IC 12-16-14 the following definitions apply:

(1) "Amount" refers to a payable claim in an amount calculated under STEP THREE of the following formula:

STEP ONE: Identify the items and services comprising a payable claim.

STEP TWO: Using the applicable Medicaid fee for service reimbursement rates, calculate the reimbursement amounts for each of the items and services identified in STEP ONE.

STEP THREE: Calculate the sum of the amounts identified in STEP TWO.

(2) "Payable claim" means a claim for hospital items or services, physician care, or transportation services:

(A) provided to a person under the hospital care for the indigent program under this article during the person's eligibility under the program;

(B) identified in a claim filed with the division; and

(C) determined to:

(i) have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(ii) to be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(c) Payable claims shall be segregated by state fiscal year.

(d) The division shall calculate the amount of a payable claim at the time referenced in IC 12-16-5.5-1.2.

(e) A physician, hospital, or transportation provider that submits a payable claim to the division is considered to have submitted the payable claim during the state fiscal year during which the division determined, initially or upon appeal, the amount of a payable claim.

(f) Hospital items or services, physician care, or transportation services provided between July 1, 2003, and June 30, 2004, are governed by section 2.5 of this chapter.

SECTION 27. IC 12-16-7.5-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 12. All providers receiving payment under **section 1.2 of** this chapter agree to accept, as payment in full, the ~~amount paid for the hospital care for the indigent program~~ **payment identified in section 1.2 of this chapter** for ~~those claims submitted for payment under the program, with the exception of authorized deductibles, co-insurance, co-payment, or similar cost-sharing charges.~~ **health care items or services identified in payable claims submitted to the division.**

SECTION 28. IC 12-16-12.5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. The division is responsible for the emergency medical care given in a hospital to an individual who qualifies for assistance under this chapter, subject to ~~the limitations in~~ IC 12-16-7.5.

SECTION 29. IC 12-16-12.5-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) If a hospital owned by the health and hospital corporation is:

(1) unable to care for a patient; or

(2) unable to treat a patient at the time a transfer is requested by the hospital initiating treatment;

the hospital may continue to treat the patient until the patient's discharge.

(b) Subject to ~~the limitations in~~ IC 12-16-7.5, the division shall ~~pay the costs of~~ **be responsible for** care.

SECTION 30. IC 12-16-12.5-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. The ~~division is not responsible~~ **hospital care** for **the indigent program under this article does not apply to** the following:

(1) ~~The payment of~~ Nonemergency ~~medical costs,~~ **care,** except as provided under ~~the hospital care for the indigent program.~~ **this article.**

(2) ~~The payment of medical costs accrued~~ **Care provided** at a hospital owned or operated by a health and hospital corporation, except for ~~hospital~~ care provided under this chapter to a person not residing in Marion County.

SECTION 31. IC 12-16-14-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 3. (a) For purposes of this section, **the following definitions apply:**

(1) "Amount" ~~"payable claim"~~ has the meaning set forth in ~~IC 12-16-7.5-2.5(b)(1).~~ **IC 12-16-7.5-2.7(b)(1).**

(2) "Payable claim" has the meaning set forth in IC 12-16-7.5-2.7(b)(2).

(b) For taxes first due and payable in 2003, each county shall impose a hospital care for the indigent property tax levy equal to the product of:

(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in 2002; multiplied by

(2) the county's assessed value growth quotient determined under IC 6-1.1-18.5-2 for taxes first due and payable in 2003.

(c) For taxes first due and payable in 2004, 2005, ~~and~~ 2006, **2007, and 2008,** each county shall impose a hospital care for the indigent property tax levy equal to the product of:

(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in the preceding year; multiplied by

(2) the assessed value growth quotient determined in the last STEP of the following STEPS:

STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective.

STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's

total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.

STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).

(d) Except as provided in subsection (e):

(1) for taxes first due and payable in ~~2007,~~ **2009,** each county shall impose a hospital care for the indigent property tax levy equal to the average **of the** annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the state fiscal years beginning:

~~(A) July 1, 2003;~~

~~(B) July 1, 2004; and~~

~~(C)~~ **(A)** July 1, 2005; ~~and~~

(B) July 1, 2006; and

(C) July 1, 2007; and

(2) for all subsequent annual levies under this section, the average annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the three (3) most recently completed state fiscal years.

(e) A county may not impose an annual levy under subsection (d) in an amount greater than the product of:

(1) The greater of:

(A) the county's hospital care for the indigent property tax levy for taxes first due and payable in ~~2006,~~ **2008;** or

(B) the amount of the county's maximum hospital care for the indigent property tax levy determined under this subsection for taxes first due and payable in the immediately preceding year; multiplied by

(2) the assessed value growth quotient determined in the last STEP of the following STEPS:

STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective.

STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.

STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).

(f) For purposes of this section, a payable claim is attributed to the state fiscal year during which the division determined, under IC 12-16-5.5-1.2(b) or upon appeal, the amount of the payable claim.

SECTION 32. IC 29-2-16-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 1. Except where the context clearly indicates a different meaning, the terms used in this chapter shall be construed as follows:

(a) "Bank or storage facility" means a facility licensed, accredited, or approved under the laws of any state for storage of human bodies or parts thereof.

(b) "Decedent" means a deceased individual and includes a stillborn infant or fetus.

(c) "Donor" means an individual who makes a gift of all or part of ~~his~~ **the decedent's** body.

(d) "Hospital" means a hospital licensed, accredited, or approved under the laws of any state. **The term** includes a hospital operated by the United States government, a state, or a subdivision thereof, although not required to be licensed under state laws.

(e) "Part" means organs, tissues, eyes, bones, arteries, blood, other fluids, and any other portions of a human body.

(f) "Person" means an individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

(g) "Physician" or "surgeon" means a physician or surgeon licensed or authorized to practice under the laws of any state.

(h) "Procurement organization" means an organization qualified to recover anatomical gifts from donors.

~~(h)~~ **(i)** "State" includes any state, district, commonwealth, territory, insular possession, and any other area subject to the legislative authority of the United States of America.

SECTION 33. IC 29-2-16-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 3. The following persons may become donees of gifts of bodies or parts thereof for the purposes stated:

(1) any hospital, surgeon, or physician for medical or dental education, research, advancement of medical or dental science, therapy, or transplantation; ~~or~~

(2) any accredited medical or dental school, college or university for education, research, advancement of medical or dental science, or therapy; ~~or~~

(3) any ~~bank~~ **procurement organization** or storage facility, for

medical or dental education, research, advancement of medical or dental science, therapy, or transplantation; or

(4) any specified individual for therapy or transplantation needed by ~~him.~~ **the individual.**

SECTION 34. IC 29-2-16-4.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 4.5. (a) A coroner ~~may release and permit~~ **shall attempt to facilitate permission for** the removal of ~~a part from a body~~ **organs, tissues, or eyes** within the coroner's custody, for transplantation, ~~or~~ therapy, ~~only,~~ **or research by providing information to or seeking information from the procurement organization that would assist the procurement organization in the evaluation of the viability for transplantation of any organ, tissue, or eye** if all of the following occur:

(1) The coroner receives a request ~~for a part~~ from a hospital, physician, surgeon, or procurement organization.

(2) The coroner makes a reasonable effort, taking into account the useful life of a part, to locate and examine the decedent's medical records and inform individuals listed in section 2(b) of this chapter of their option to make or object to making a gift under this chapter.

(3) The decision to allow the removal of organs, tissues, or eyes is based on a medical decision made by the pathologist or forensic pathologist. If the pathologist or forensic pathologist considers withholding one (1) or more organs or tissues of a potential donor, the pathologist or forensic pathologist:

(A) shall be present during the removal of the organs or tissues;

(B) may request a biopsy of the removed organs; and

(C) after viewing the removed organs or tissues and determining that removal may interfere with the death investigation, may prohibit removal and shall provide a written explanation to the procurement organization.

If it is determined that prior removal will interfere with the death investigation, the procurement organization may remove the tissues and eyes after the autopsy.

~~(3)~~ **(4)** The coroner does not know of a refusal or contrary indication by the decedent or an objection by an individual having priority to act as listed in section 2(b) of this chapter.

~~(4)~~ **(5)**The removal will be by:

(A) a physician licensed under IC 25-22.5; or

(B) in the case of removal of an eye or part of an eye, by an individual described in section 4(e) of this chapter; and under

IC 36-2-14-19.

~~(5)~~ **(6)** The removal will not interfere with any autopsy or investigation.

~~(6)~~ **(7)** The removal will be in accordance with accepted medical standards.

~~(7)~~ **(8)** Cosmetic restoration will be done, if appropriate.

(9) If the pathologist or forensic pathologist is required to be present to examine the decedent before or during the removal of the parts, the procurement organization shall reimburse the pathologist or forensic pathologist for actual costs, but the amount may not exceed one thousand dollars ($1,000). The county is not responsible for any costs incurred by the pathologist, forensic pathologist, or procurement organization under this subdivision.

(10) If requested by the coroner, pathologist, or forensic pathologist, the procurement organization shall provide a surgeon's report detailing the condition of the organs and the relationship of the organs to the cause of death, if any.

(b) If the body is not within the custody of the coroner, the ~~medical examiner~~ **pathologist or forensic pathologist** may release and permit the removal of any part from a body ~~in the medical examiner's custody~~ for transplantation or therapy if the requirements of subsection (a) are met.

(c) A person under this section who releases or permits the removal of a part shall maintain a permanent record of the name of the decedent, the individual making the request, the date and purpose of the request, the body part requested, and the person to whom it was released.

SECTION 35. IC 29-2-16-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 6.5. (a) Except for a gift made by a donor to a specific donee, a procurement organization that holds an agreement with a hospital to perform anatomical gift donation services for the hospital under 42 U.S.C. 1329b-8 and 42 CFR Part 482 is considered to be the donee of all gifts from patients who have died in the hospital.**

(b) An investigation by a coroner or a medical examiner does not change the rights of a procurement organization to act as the donee.

SECTION 36. IC 34-30-2-45.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 45.2. IC 12-16-2.5-6.5**

(Concerning administering agreements between the hospital and the division of family and children under the hospital care for the indigent program).".

Page 4, between lines 13 and 14, begin a new paragraph and insert:

"SECTION 38. THE FOLLOWING ARE REPEALED [EFFECTIVE UPON PASSAGE]: IC 12-16-2.5-3; IC 12-16-6.5-2; IC 12-16-7.5-1; IC 12-16-11.5-1; IC 12-16-11.5-2.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 66 as reprinted March 1, 2005.)

BECKER, Chair

Committee Vote: yeas 8, nays 0.

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 66 be amended to read as follows:

Page 3, line 41, after "obligation" insert "**under IC 12-16-7.5-1.2**".

Page 3, line 42, delete "person under" and insert "**person.**".

Page 4, delete line 1.

Page 5, line 5, delete "determination" and insert "**determinations**".

Page 6, line 1, delete "resident's" and insert "**individual's**".

Page 8, line 23, after "or" insert "**with**".

Page 9, line 39, delete "at least" and insert "**a period of time, not less than**".

Page 9, line 40, delete "IC 12-16-6.5-1.5 to provide" and insert "**IC 12-16-6.5-1.5, to submit to**".

Page 9, line 41, delete "with".

Page 10, line 2, after "eligible" insert "**without the division's determination**".

Page 10, line 7, after "unable" and insert "**after prompt and diligent efforts**".

Page 10, line 40, after "that" delete "the" and insert "**an**".

Page 11, line 1, before "The" begin a new paragraph and insert:

"**(c)**".

Page 11, line 1, delete "time to" and insert "**a period of time, not less than ten (10) days beyond the deadline under IC 12-16-6.5-1.7, to submit to the division**".

Page 11, line 2, delete "provide the division with".

Page 11, line 6, after "IC 12-16-3.5-2(a)(3), or" insert "**was**".

Page 11, delete lines 8 through 9.

Page 11, line 10, delete "IC 12-16-6.5-1.7." and insert "**IC 12-16-3.5-1(a)(3).**".

Page 11, line 13, after "considered" insert "**, without the division's determination,**".

Page 11, line 16, delete "IC 12-16-3.5-2(a)(3), or" and insert "**IC 12-16-3.5-2(a)(3) or to have been**".

Page 11, line 29, delete "TO READ TO READ" and insert "TO READ".

Page 12, line 24, delete "financial and medical".

Page 12, line 27, after "eligible" insert "**without the division's determination**".

Page 12, line 32, delete "IC 12-16-5.5-3.2(b)," and insert "**IC 12-16-5.5-3.2(c)**".

Page 12, line 35, after "IC 12-16-4.5," insert "**without the division's determination**".

Page 13, line 33, delete "must receive" and insert "**is entitled to**".

Page 14, line 24, delete "must" and insert "**may**".

Page 14, line 28, delete "must" and insert "**may**".

Page 14, line 31, delete "in".

Page 14, line 31, delete "must" and insert "**may**".

Page 15, line 24, after "IC 12-16-14" insert "**,**".

Page 16, line 22, delete "identified" and insert "**referred to**".

Page 16, line 25, after "charges." insert "**the**".

Page 18, line 41, delete "under".

Page 18, line 42, delete "IC 12-16-5.5-1.2(b)" and insert "**initially**".

(Reference is to ESB 66 as printed March 25, 2005.)

BECKER

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 66 be amended to read as follows:

Page 2, line 23, delete "December 31, 2007." and insert "**April 1, 2006.**".

(Reference is to ESB 66 as printed March 25, 2005.)

BECKER

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 66 be amended to read as follows:

Page 3, between lines 10 and 11, begin a new paragraph and insert:

"SECTION 3. IC 12-15-12-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. (a) A Medicaid recipient may be admitted to a hospital by a physician other than the recipient's managed care provider if the recipient requires immediate medical treatment.

(b) The admitting physician shall notify the recipient's managed care provider of the recipient's admission not more than forty-eight (48) hours after the recipient's admission.

(c) Payment for services provided a recipient admitted to a hospital under this section shall be made only for services that the office or the contractor under IC 12-15-30 determines were medically reasonable and necessary.

(d) A physician who provides physician services in the emergency department of a hospital licensed under IC 16-21 to a recipient of services from a managed care organization shall notify the managed care organization not later than five (5) business days after the physician provided a service to the recipient. The managed care organization may specify the procedure by which the physician must notify the managed care organization, including that the notice may be in written or electronic format.

SECTION 4. IC 12-15-12-18.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 18.5. (a) Subject to federal law, a managed care organization may establish policies to control the inappropriate utilization of emergency room services by a recipient.**

(b) Before a managed care organization may implement a policy under subsection (a), the managed care organization shall notify each Medicaid recipient at least thirty (30) days before implementing the policy.

(c) A recipient may appeal under IC 4-21.5 the implementation of a policy under subsection (a).".

Page 3, line 33, reset in roman "(e) This section does not apply to".

Page 3, line 33, reset in roman "the Medicaid".

Page 3, reset in roman line 34.

Page 3, between lines 34 and 35, begin a new paragraph and insert:

"SECTION 4. IC 12-15-15-2.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2005]: **Sec. 2.7. (a) This section applies to a physician who:**

(1) provides services in an emergency department of a hospital licensed under IC 16-21; and

(2) does not have a contract with a managed care organization.

(b) For services rendered and documented in an individual's medical record, physicians must be reimbursed for federally required medical screening exams that are necessary to determine the presence of an emergency using the appropriate Current Procedural Terminology (CPT) codes 99281, 99282, or 99283 described in the Current Procedural Terminology Manual published annually by the American Medical Association, without authorization by the enrollee's primary medical provider.

(c) A physician may agree to provide the services described in subsection (b) for:

(1) a negotiated rate other than one hundred percent (100%) of the rate payable under the Medicaid fee structure; or

(2) one hundred percent (100%) of the rate payable under the Medicaid fee structure.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 66 as printed March 25, 2005.)

BROWN T